U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 August 2007

Case No. 2006-BLA-5611

In the Matter of:
E.M.[1], Widow of D.M.,
Claimant,

v.

MEALLY COAL CO. INC.,
Employer,
and,
AMERICAN BUSINESS & MERCANTILE
INSURANCE MUTUAL, INC.,
Carrier,
and,

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party in Interest.

APPEARANCES:
Stephen A. Sanders, Esq.
On behalf of Claimant

John T. Chafin, Esq.
On behalf of Respondent

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

[1] Effective August 1, 2006, the Department of Labor directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site and to insert initials of such claimant/parties in the place of those proper names. In support of this policy change, DOL has adopted a rule change to 20 C.F.R. Section 725.477, eliminating a requirement that the names of the parties be included in decisions. Further, to avoid unwanted publicity of those claimants on the web, the Department has installed software that prevents entry of the claimant's full name on final decisions and related orders. This change contravenes the plain language of 5 U.S.C. 552(a)(2) (which requires the Internet publication), where it states that "in ***each case*** the justification for the deletion [of identification] shall be explained fully in writing." (*emphasis added*). The language of this statute clearly prohibits a "catch all" requirement from the OALJ that identities be withheld. Even if §725.477(b) gives leeway for the OALJ to no longer publish the names of Claimants – 5 U.S.C. 552(a)(2) clearly requires that the deletion of names be made on a case by case basis.

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On April 18, 2006, the Director, Office of Workers' Compensation Programs referred this case to the Office of Administrative Law Judges for a formal hearing. (DX 36).[3] The undersigned Administrative Law Judge conducted a formal hearing on this matter on February 22, 2007 in Prestonsburg, Kentucky. All parties were afforded the opportunity to call and to examine and cross-examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[4]

The issues in this case are:

1. Whether the Miner had pneumoconiosis as defined by the Act;

I also strongly object to this policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank*, 951 F. 2d 320 (11th Cir. 1992) and those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). This change in policy rebukes the long standing legal requirement that a party's name be anonymous only in "*exceptional cases*." *See Doe v. Stegall*, 653 F.2d 180, 185 (5th Cir. 1981), *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993), *and Frank* 951 F.2d at 323 (noting that party anonymity should be rarely granted)(*emphasis added*). As the Eleventh Circuited noted, "[t]he ultimate test for permitting a plaintiff to proceed anonymously is whether the plaintiff has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings." *Frank*, 951 F.2d at 323.

Finally, I strongly object to the specific direction by the DOL that Administrative Law Judges have a "mind-set" to use the complainant/parties' initials if the document will appear on the DOL's website, for the reason, *inter alia*, that this is not a mere procedural change, but is a "substantive" procedural change, reflecting centuries of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge's decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial "mind-set" constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[3] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[4] Employer listed other issues that will not be decided by the undersigned; however, they are preserved for appeal. (Item 18(B) DX 36).

2. Whether the Miner's pneumoconiosis arose out of coal mine employment; and

3. Whether the Miner's death was due to pneumoconiosis.

(DX 36).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

D.M., ("Miner"), was born on September 15, 1926. (DX 3). He married E.M. ("Claimant") on July 3, 1948, and they remained married until Miner's death on October 6, 1998. (DX 3, 8,35). Miner and Claimant do not have any dependent children. (DX 3). I find that Claimant is an eligible surviving spouse of Miner.

In an affidavit dated April 22, 2002, Claimant stated that because of coal mining, Miner suffered from a bad cough, he could not breathe, he was short of breath, he would spit up black phlegm, he had a bad heart, and he had to sleep on two pillows or in a chair. (DX 14). In support, she explained that for the 22 years preceding his death his activity was limited because he could not do anything that would require use of his breath.

Procedural History

Miner filed a claim for benefits on July 31, 1985. (DX 1). On January 7, 1986, the District Director, OWCP issued a letter denying Miner's claim, finding that he failed to satisfy any of the elements of entitlement.

Miner died on October 6, 1998. (DX 9). Claimant filed a claim for survivor benefits on March 5, 2002. (DX 3). On May 23, 2003, the District Director, OWCP issued a proposed decision and order denying benefits. (DX 26). Claimant timely requested a formal hearing. (DX 29). The matter was transferred to the Office of Administrative Law Judges on July 25, 2003, and a hearing was conducted on May 19, 2004, but the matter was remanded by Judge Craft in order for the parties to develop evidence in compliance with the limitations and to allow reconsideration of the proposed decision in light of the admissible evidence. (DX 35). On December 14, 2005, the Director issued a letter allowing 30 days for the parties to submit evidence before the matter was returned to the Office of Administrative Law Judges. (DX 35: 3, 13). On April 18, 2006, this matter was transferred to the Office of the Administrative Law Judges. (DX 36).

Length of Coal Mine Employment

The Social Security Earnings records and the other evidence of record establishes, and I find, that Miner was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations. The parties stipulated that Miner engaged in at least 19 years of coal mine employment. (DX 34:1) Since the parties' stipulation is supported by the record, (DX 4-6, 21). I find that Miner engaged in at least 19 years of coal mine employment.

Miner's last employment was in the Commonwealth of Kentucky (DX 4, 35); therefore, the law of the Sixth Circuit is controlling.[5]

Responsible Operator

Liability under the Act is assessed against the most recent operator that meets the requirements of §§ 725.494 and 725.495. The District Director identified Meally Coal Co. Inc. as the most recent operator to employ Miner for at least one year. (DX 16, 26). Meally Coal Co. Inc. does not contest this issue. (Tr. 6). After review of the record, I find that Meally Coal Co. Inc. is properly designated as the responsible operator in this case.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 8). Claimant designated x-ray interpretations by Drs. Bassali and Ahmed as initial and rebuttal evidence; PFT and ABG studies by Dr. Anderson; medical reports by Drs. Jurich and Anderson; and the treatment records designated at DX 11, 12 and 24. Claimant's evidence complies with

[5] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

the requisite quality standards of §§ 718.102-107 and the limitations of § 725-414 (a)(3). Therefore, I admit the evidence Claimant designated in its summary form. Finally, Claimant submitted but did not designate a copy of Miner's amended death certificate. I find that good cause exists to include this report, as well as the original death certificate, in the instant adjudication.

Employer completed a Black Lung Benefits Act Evidence Summary Form. (EX 9). Employer designated Dr. Wiot's interpretations of the February 18, 1998 and the February 10, 1998 chest x-ray as initial evidence. Employer also designated PFT and ABG studies by Dr. Sutherland; Dr. Broudy's November 2006 medical report, a December 2006 supplemental report, and a January 2007 deposition; and Dr. Fino's December 2006 medical report and his January 2007 supplemental report. Finally, Employer designated the treatment records found in DX 12. With exception of the rebuttal x-ray interpretations found in EX 2,[6] Employer's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725-414 (a)(3). Therefore, I admit the remaining evidence Employer designated in its summary form.

X-RAYS

Exhibit	Date of X-ray	Date of Reading	Physician / Credentials	Interpretation
CX 3	10/4/84	11/19/84	Bassali, BCR, B-reader	2/3 st
EX 1	2/10/98	06/25/04	Wiot, BCR[7],B-reader[8]	Negative
CX 6	2/10/98	02/19/07	Ahmed, BCR, B-reader	2/1 tt
EX 1	2/18/98	06/25/04	Wiot, BCR, B-reader	Negative
CX 7	2/18/98	02/19/07	Ahmed, BCR, B-reader	1/2 tt

PULMONARY FUNCTION TESTS

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results
EX 3 9/11/85	Good/ Good/ Yes	58 69.5"	2.91	3.67	113	79	No

[6] Employer also designated Dr. Wiot's interpretations of the February 12 and 16, 1998 chest x-rays as rebuttal evidence. (EX 2). By order dated July 3, 2007, I found these interpretations inadmissible per the limitations of §725.414.

[7] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[8] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

CX 5 5/14/85	Not listed/ Not listed/ No	58	2.81	3.75	114.8	75	No

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**
EX 3	9/11/85	38 36*	79 119*	No No*
CX 5	5/14/85	36.6	66.3	No
DX 12	2/10/98	36	71	No

* Indicates post-exercise values

Hospital and Treatment Records

The record contains treatment notes from the Highlands Regional Medical Center, Paul B. Hall Regional Medical Center, and the VA Medical Center. (DX 11-12, 24).[9] These records span from May 1996 through April 1998**,** and the entries pertinent to this claim for benefits are reproduced below in chronological order.

July 16, 1996 – X-ray report by Dr. Roth: No evidence of acute pulmonary or cardiac abnormality. (DX 24).

July 18, 1996 – Discharge report by Dr. Pellecchia: Physical examination reveals diffuse wheezes and rhonchi. Diagnosis: status post cerebrovascular accident with resultant hemiplegia and aphasia. (DX 24).

October 1, 1996 – Discharge report by Dr. Lockhart: Patient was admitted post-stroke. The physical examination was within normal limits and the x-ray was negative. Diagnosis: possible recent cerebrovascular accident, aspiration requiring percutaneous endoscopic gastrostomy tube placement, and urinary tract infection. (DX 24).

October 3, 1996 – X-ray report by Dr. Zarabi: No active disease is demonstrated in either lung. (DX 24).

October 7, 1996 – X-ray report by Dr. Zarabi: Infiltrative changes in the left lower lobe. (DX 24).

[9] This treatment record includes several x-ray interpretations. There is no evidence in the record as to the x-ray reading credentials of the providing physicians. Also, several of these interpretations were related to the treatment of Miner's condition, and not taken for the purpose of determining the existence or extent of pneumoconiosis. Finally, there is no record of the film quality for any of these x-rays. As a result, the treatment x-ray results are not in compliance with the quality standards of §718.102 and Appendix A to Part 718, and will not be considered under § 718.202(a)(1).

July 31, 1997 – Examination report by Dr. Lockhart: Physical examination revealed bilateral mild rhonchi that cleared with cough. X-ray showed interstital pulmonary disease and atelectasis in the mid portion of the lung. Diagnosis: Cerebrovascular accident with right hemiplegia and aphasia, hypertension, and seizure disorder. (DX 24).

August 1, 1997 – X-ray report by Dr. Zarabi: Interstitial pulmonary disease and atelectasis in the mid portion of the right lung. (DX 24).

February 10, 1998 – ABG study (charted above). (DX 12).

February 10, 1998 – X-ray report by Dr. Joshi: There are basilar infiltrates bilaterally, more on the right. Additional infiltrative change is seen in the right mid lung filed. The pleural linguals are not well defined, especially on the right. There is no pulmonary congestion. The pulmonary infiltrates may represent inflammatory or fibrotic etiology. (DX 12).

February 12, 1998 – Consultation report by Dr. Sikder: Patient has 100 pack-year smoking history, quitting in 1995, and a 50-year coal mine employment history. Physical examination revealed coarse breath sounds bilaterally with a few scattered rhonchi in both lung fields. X-ray revealed increased interstitial infiltrate in both lung fields. Diagnosis: bilateral pneumonia, , COPD, CWP, fibrotic lung disease secondary to COPD and CWP, CVA, UTI, and dehydration. (DX 12).

February 16, 1998 – x-ray report by Dr. Joshi: Increase in the basilar pulmonary infiltrates since 2/10/08, no evidence of CHF, much older films are requested for comparison as some of the infiltrative changes may be chronic in nature. (DX 12).

February 18, 1998 – X-ray report by Dr. Joshi: Left lower lobe is clear and the right lung remains unchanged since 2/16/98. (DX 12).

February 25, 1998 – Discharge report by Dr. Guzman: Patient had strokes in 1985, 1987, and 1997 and a history of MI. Physical examination revealed bilateral basal rales scattered over both lung fields, mostly at the bases. Chest x-ray showed clearing of the left lower lobe, and an ABG was conducted. Diagnosis: aspiration pneumonia, urinary tract infection, COPD with exacerbation, dehydration, and nutritional anemia. (DX 12).

April 30, 1998 – Discharge summary by Dr. Jurich: Patient was admitted with a diagnosis of aspiration pneumonia, COPD, cerebrovascular accident with right hemiplegia, and dehydration. Symptomatology included dyspnea at rest and on exertion, and cough with copious amounts of thick yellow mucus. Previous medial history included a cerebrovascular accident with right hemiplegia. Physical examination revealed bilateral rales, rhonchi, and right crepitations. EKG showed generalized ischemia and right bundle branch block. X-ray revealed congestive heart failure and interstitial and alveolar pulmonary edema with right greater than left pleural effusion. Subsequent x-ray showed resolving congestive heart failure and pulmonary edema and improvement in the bibasilar atelectasis with moderate right pleural effusion. Patient was transferred back to the nursing home. Diagnosis: Chronic heart failure, COPD, cerebrovascular accident with aphasia and right hemiplegia, and gastrointentinal bleeding. (DX 11).

Death Certificate

The death certificate, signed by Dr. Roger Jurich on October 9, 1998, shows the Miner died on October 6, 1998. (DX 9). Dr. Jurich listed that death was due to cerebra vascular accident and extrusion, urinary tract infection, seizure disorder, and COPD. The form also states that congestive heart failure was a significant condition that contributed to death but that it did not result in the underlying cause of death.

The amended death certificate, which was apparently recorded 5 ½ years after Miner's death, includes the typewritten addition of CWP as an additional condition that contributed to death but did not result in the underlying cause of death. (DX 9). I note that there is no evidence that this additional notation was added by Dr. Jurich, as his original 1998 signature remains unchanged.

Narrative Medical Opinions

Dr. William Anderson submitted a letter dated June 7, 1985. (CX 4). Dr. Anderson considered the following: employment history (30 years coal mine employment), symptomatology (shortness of breath, cough, sputum production, and chest pain), smoking history (25 years of smoking ½ to ¾ packs per day), a PFT (normal), an ABG (mild arterial hypoxia), physical examination (clear lungs), an EKG (normal), and an x-ray (category 1 pneumoconiosis). Based on this evidence, Dr. Anderson diagnosed category 1 pneumoconiosis with symptoms of arteriosclerotic heart disease with exertional and paroxysmal nocturnal dyspnea.

Dr. Roger Jurich, Miner's treating physician, submitted a letter dated February 10, 2006. (CX 1). Noting 20 years of coal mine employment, Dr. Jurich diagnosed COPD caused by coal mine employment. He noted abnormal ABG values, increased A and P diameter on physical examination and radiological findings as support for his opinion. Furthermore, while Dr. Jurich opined that coal dust was the primary contributor to Miner's respiratory condition, he also added that the chronic lung condition was partially related to a history of cigarette smoking. He concluded that pneumoconiosis both contributed to and hastened Miner's death,

Dr. Bruce Broudy, an internist, pulmonologist, and B-reader, submitted a medical evidence review on November 16, 2007, in which he considered the death certificate and Miner's medical treatment records. (EX 4). Based on the x-ray evidence, Dr. Broudy stated that Miner may have had simple pneumoconiosis, but he admitted that the evidence was mixed. However, even if Miner had simple pneumoconiosis, Dr. Broudy concluded that such condition would not have caused or contributed to death.

Dr. Broudy submitted a supplemental report on December 28, 1996, in which he considered Dr. Jurich's February 2006 letter. (EX 6). Based on the evidence considered in the previous report, Dr. Broudy disagreed with Dr. Jurich's opinion and dismissed it as a conclusory report without evidentiary support.

Dr. Broudy was deposed by the Employer on January 25, 2007, when he repeated the findings of his earlier written report. (EX 8). He explained that death was solely the result of a stroke that occurred on October 6, 1998, and that death was not caused or hastened by CWP. In fact, he noted that he has never seen evidence linking coal dust exposure to a stroke. He added that he would have expected death to have been the same regardless of whether Miner was ever employed as a coal miner. Furthermore, Dr. Broudy explained that the evidence Dr. Jurich relied on to support his finding of pneumoconiosis is more consistent with cigarette smoking.

Dr. Gregory Fino, an internist, pulmonologist, and B-reader, submitted a medical evidence review on December 1, 2006, in which he considered the medical treatment records and Dr. Jurich's letter. (EX 5). Dr. Fino said that there was no positive chest x-rays. He also stated that there were no pulmonary function studies showing a ratio of 70% or less, so there was no objective evidence of obstructive lung disease. Dr. Fino also noted that Miner's most recent hospitalization was primarily for the treatment for complications from a stroke, and that there was absolutely no evidence to suggest that a pulmonary disease, regardless of cause, played any role in Miner's death. Finally, assuming that Miner suffered from CWP, Dr. Fino opined that it caused no impairment or disability and it did not cause, contribute to, or hasten death. He concluded that Miner would have died as when he did had he never stepped foot in the coal mines.

Dr. Fino submitted a supplemental report on January 5, 2007. (EX 7). This report is identical to his prior report, except that he removed Dr. Jurich's report from consideration.

Smoking History

Claimant testified that Miner smoked a pack of cigarettes per day, but he quit in 1985. (DX 35:87-88). Dr. Anderson reported a 25 year smoking history at a rate of ½ to ¾ packs per day, ending in 1982. (CX 4). Dr. Sikder reported a 100 pack-year smoking history, quitting in 1995. (DX 12). Dr. Lockhart reported that Claimant smoked two packs of cigarettes per day, but quit in 1996. (DX 24). These records reveal that Claimant smoked from 1951 until 1996, or 45 years. His rate of smoking, however, ranges from ½ packs per day to 2 packs per day. As the evidence is so divergent, I will average these extremes and hold that Claimant smoked 1 ¼ packs per day. Therefore, I find that Miner has a smoking history of 45 years at a rate of 1 ¼ packs per day, or 56 ¼ pack-years.

DISCUSSION AND APPLICABLE LAW

E.M. filed her claim on March 22, 2002. (DX 3). Entitlement to benefits must be established under the regulatory criteria at Part 718. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). The Act provides that benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. § 718.205(a). In order to receive benefits, the claimant must prove that:

1). The miner had pneumoconiosis;

2). The miner's pneumoconiosis arose out of coal mine employment; and

3). The miner's death was due to pneumoconiosis.

§§ 718.205(a). Failure to establish any of these elements by a preponderance of the evidence precludes entitlement. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical or "clinical" pneumoconiosis and statutory or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The record includes five interpretations of three chest x-rays. Dr. Bassali, a radiologist and B-reader, interpreted the October 1984 film as positive for pneumoconiosis. There were no negative interpretations. Therefore, I find that the October 1984 film is positive for the disease.

Dr. Wiot, a radiologist and B-reader, interpreted the February 10, 1998 x-ray as negative. Dr. Ahmed, also a radiologist and B-reader, read the film as positive. As both of these physicians are equally credentialed, and since they disagree as to the results, I find that the February 10, 1998 x-ray is inconclusive.

Dr. Wiot interpreted the February 10, 1998 x-ray as negative. Dr. Ahmed read the film as positive. As both of these physicians are equally credentialed, and since they disagree as to the results, I find that the February 10, 1998 x-ray is inconclusive.

I have found that the October 1984 x-ray is positive for pneumoconiosis, and the two subsequent films are negative. However, since the 1984 film is no longer available for rebuttal interpretation, and since it is fourteen years more remote than the two 1998 films, I accord this x-ray little weight. As a result, I find that the most probative x-ray evidence, as read by dually credentialed physicians, is inconclusive for the disease. Therefore, I find that Claimant has not established the existence of pneumoconiosis through x-ray evidence under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based upon biopsy or autopsy evidence. The evidentiary record does not contain any biopsy or autopsy evidence. Therefore, I find that the Claimant has not established the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is

one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. Sikder diagnosed COPD, CWP, and fibrotic lung disease secondary to COPD and CWP. In reaching this opinion, he considered 50 years of coal mine employment and a 100 pack-year smoking history. He also conducted a physical examination and considered non-ILO classified x-ray results. It is proper for an ALJ to discredit a medical opinion based on an inaccurate length of coal mine employment. *Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993)(per curiam) (physicians reported an eight year coal mine employment history, but the ALJ only found four years of such employment); *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993) (physician's opinion less probative where based on inaccurate smoking history). As I have found that Claimant worked in coal mines for approximately 19 years, and that he has a 56 ¼ pack-year smoking history, I find that Dr. Sikder consideration of approximately twice the smoking and coal mine employment histories drastically diminishes the weight of his opinion. Furthermore, I have found the x-ray evidence in this case to be inconclusive, and I have also found that the film Dr. Sikder considered in reaching his opinion was not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Thus, the only reliable portion of his consultation report is the physical examination. However, I note that he has not provided any explanation as to how these physical findings support a finding that his respiratory condition was caused by coal dust exposure. *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis). Therefore, based on these factors, I find that Dr. Sikder's opinion is inadequately well-reasoned and documented to support a finding of pneumoconiosis, and thus, I accord his opinion little weight.

Dr. Jurich opined that Miner suffered from COPD cause by coal mine employment. He cited ABG values, physical examination results, and x-ray evidence. I note, however, that Dr. Jurich's conclusion does not clarify which objective results he considered in reaching his opinion, nor does he explain how this evidence supports his conclusion that coal dust was a contributor to Claimant's alleged COPD. Dr. Jurich was aware that Miner had previously been a smoker, but at no point does he mention how much smoking history he considered in determining that coal dust was the primary cause of the COPD.

I am also not inclined to give Dr. Jurich's conclusory letter additional weight based on his status as a treating physician. The treatment records include evidence that he treated Miner in conjunction with the April 1998 admission. There is, however, no evidence that the physician-patient relationship extended beyond this single hospital course six months preceding Miner's death. In addition, the first time Dr. Jurich even mentioned the possibility of pneumoconiosis was in his February 2006 letter. While the April 1998 discharge summary diagnosed COPD, at no point did he opine that this condition was caused by coal dust exposure. Furthermore, while the amended death certificate states that Miner suffered from CWP, this notation was apparently added 5 ½ years after Dr. Jurich signed the document and there is no evidence to support the conclusion that he added this diagnosis to report. Therefore, considering all of these

deficiencies, I find that Dr. Jurich's report is insufficiently well-reasoned and documented to support a diagnosis of pneumoconiosis. Thus, I accord his opinion little weight.

Dr. Anderson diagnosed category 1 pneumoconiosis based on an unspecified x-ray. While he also considered employment history, physical examination results, and PFT and ABG values, his pneumoconiosis diagnosis was clearly based solely on the x-ray evidence. The Sixth Circuit Court of Appeals has held that merely restating an x-ray is not a reasoned medical judgment under § 718.202(a)(4). *Cornett v. Benham Coal, Inc*., 227 F.3d 569 (6th Cir. 2000). As a result, I find that Dr. Anderson's pneumoconiosis diagnosis is not a reasoned medical opinion under § 718.202(a)(4). Thus, I accord his opinion regarding pneumoconiosis no weight.

Dr. Broudy concluded that Miner may have simple pneumoconiosis, but he also opined that the x-ray evidence was mixed. I find that his report does not constitute a reasoned medical opinion under § 718.202(a)(4). First, like Dr. Anderson, he based his opinion solely on the x-ray evidence he considered. *Id.* Second, I find that by stating that Miner "may" have pneumoconiosis, Dr. Broudy has offered an equivocal diagnosis. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease). Thus, I accord his opinion regarding pneumoconiosis no weight.

Dr. Fino opined that since there were no positive chest x-rays, and since there were no PFTs showing a ratio of less than 70%, there was no objective evidence of pneumoconiosis or obstructive lung disease. I find that Dr. Fino's opinion is adequately based on the objective evidence he considered. Therefore, bolstered by his advanced credentials, I accord his opinion probative weight.

The record is replete with equivocal, unsupported, and conclusory opinions that Miner suffered from pneumoconiosis. Dr. Sikder based his opinion on inaccurate smoking and coal mine employment histories, as well as x-ray evidence that was not in compliance with the quality standards. I found that he failed to provide an adequate explanation as to how the remainder of the objective evidence he considered supported his diagnosis. While Dr. Jurich considered objective evidence in diagnosing COPD prior to Miner's death, his opinion that the cause of this COPD was primarily coal dust exposure was not offered until 5 ½ years after Miner's death, and there is no evidence as to the specific evidence he considered in reaching this conclusion. Furthermore, while Dr. Jurich noted a smoking history, there is no record as to how much smoking he considered, or why Miner's COPD was not solely attributable to tobacco smoke. Based on these deficiencies, I accorded both Dr. Sikder's and Dr. Jurich's opinions little weight.

I also found that Drs. Broudy and Anderson's opinions do not constitute reasoned medical opinion under § 718.202(a)(4) due to their reliance on x-ray evidence. While Dr. Anderson clearly reviewed other objective evidence in preparing his report, his diagnosis of category 1 pneumoconiosis was solely based on the x-ray evidence. Similarly, I found Dr. Broudy's "may have" diagnosis to be equivocal, and based entirely on the x-rays.

Upon review of the medical narrative evidence, I find that the only well-reasoned and documented opinion is that of Dr. Fino. While Dr. Fino's opinion did not take into consideration all of the objective evidence of record, namely the x-ray interpretations considered under § 718.202(a)(1) or the September 1985 PFT, his conclusion was adequately based on the evidence he considered. I further note that in preparation of report, he considered the same evidence that was before Drs. Jurich and Sikder when they rendered their opinions, namely the treatment records. Therefore, based on all of the medical reports, I find Dr. Fino's opinion to be the most probative, and thus, Claimant has not proven the existence of pneumoconiosis under § 718.202(a)(4).

Claimant has failed to establish the presence pneumoconiosis under subsections (a)(1)-(4). Therefore, after weighing all evidence of pneumoconiosis together under §718.202 (a), I find that Claimant has failed to establish the presence of pneumoconiosis by a preponderance of the evidence.

The Board has held that, in a survivor's claim under Part 718, the administrative law judge must make a threshold determination as to the existence of pneumoconiosis under §718.202(a) prior to considering whether the miner's death was due to pneumoconiosis. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993). Therefore, as Claimant has not proven the existence of pneumoconiosis under §718.202(a), I find that it is not necessary to determine whether Miner's death was due to pneumoconiosis.[10]

Entitlement

Claimant has failed to prove, by a preponderance of the evidence, that Miner suffered from pneumoconiosis arising out of coal mine employment**,** or that his death was due to pneumoconiosis. Therefore, I find that she is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

[10] Even if I had found that Miner had pneumoconiosis, there is insufficient evidence to demonstrate that his death was either due to, or hastened by, pneumoconiosis. The only evidence in support of such a finding is the questionable, amended death certificate, and Dr. Jurich's unsupported and conclusory statement that Miner's pneumoconiosis both contributed and hastened death. Therefore, even assuming that Miner suffered from pneumoconiosis, the decision to deny benefits under the act would remain unchanged.

ORDER

IT IS ORDERED that the claim of E.M. for benefits under the Act is hereby DENIED**.**

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).